**State of Maine**

**Department of Health & Human Services (DHHS)**

**MaineCare**

# Medicaid Management Information Systems
## *Maine Integrated Health Management Solution*
## *CMS 1500 Billing Instructions Guide*

# Revision History

| Version | Date | Author | Action/Summary of Changes | Status |
|---------|------|--------|---------------------------|--------|
| 1.0 | 01/11/2010 | M Smith | Changes accepted and made final. | Final |
| 1.3 | 8/12/2010 | K. Goldhammer | Edits made based on State review meeting. Note for version 2 publication; "This edition inclusive of all revisions in Update 1." | Draft |
| 2.0 | 8/13/2010 | M Smith | Changes accepted and made final. | Final |
| 2.1 | 03/25/2012 | K. Goldhammer, P. Foster | Updates from billing changes. Removed MeCMS to MIHMS transition references | Draft |
| 2.1 | 04/02/2012 | Pam Foster | Quality Assurance and formatting | Draft |
| 2.2 | 05/09/2012 | Pam Foster | State comments incorporated from J. Palow email dated 5/2/2012 | Draft |
| 3.0 | 05/16/2012 | Pam Foster | Received approval from State | Final |
| 3.1 | 11/08/2013 | Hilary McIntire | Incorporated Billing Changes (Update 01, 02 and 03) | Draft |
| 3.1 | 11/14/2013 | Darcy Casey | QA Review | Draft |
| 3.2 | 12/03/2013 | Hilary McIntire | Updates per State Comment Log v3.1 dated 12/02/2013 | Draft |
| 3.2 | 12/06/2013 | Darcy Casey | QA Review | Draft |
| 3.3 | 01/30/2014 | Darcy Casey | Updates per State comment log v3.2 dated 1/23/2014 | Draft |
| 4.0 | 02/03/2014 | Darcy Casey | Finalization per State acceptance email dated 02/03/2014 | Final |
| 4.1 | 03/11/2014 | Hilary Mcintire | Updates per CR35494 and 37954 | Draft |
| 4.1 | 03/24/2014 | Darcy Casey | QA Review | Draft |
| 4.2 | 04/15/2014 | Hilary McIntire | Updates per State comment log v4.1 dated 4/9/2014 | Draft |
| 4.2 | 04/24/2014 | Darcy Casey | QA Review | Draft |
| 4.3 | 05/06/2014 | Hilary McIntire | Updates per State comment log v4.2 dated 4/30/2014 | Draft |
| 4.3 | 05/07/2014 | Darcy Casey | QA Review | Draft |

| Version | Date | Author | Action/Summary of Changes | Status |
|---------|------|--------|---------------------------|--------|
| 5.0 | 05/12/2014 | Darcy Casey | Finalization per State acceptance email dated 05/12/2014 | Final |
| 5.1 | 06/03/2014 | Hilary McIntire | Updates to Table 1 | Draft |
| 6.0 | 06/24/2014 | Darcy Casey | Finalization | Final |
| 6.1 | 08/06/2015 | Darcy Casey | ICD-10 updates to Box 21 and Box 24A | Draft |
| 7.0 | 08/11/2015 | Darcy Casey | Finalization per State approval email dated 08/11/2015 | Final |
| 8.0 | 08/30/2016 | Pam Foster | Updates to Box 24D per AI56374 | Final |

# Usage Information

Documents published herein are furnished "As Is." There are no expressed or implied warranties. The content of this document herein is subject to change without notice.

# HIPAA Notice

This Maine Health PAS Online Portal is for the use of authorized users only. Users of the Maine Health PAS Online Portal may have access to protected and personally identifiable health data. As such, the Maine Health PAS Online Portal and its data are subject to the Privacy and Security Regulations within the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA).

By accessing the Maine Health PAS Online Portal, all users agree to protect the privacy and security of the data contained within as required by law. Access to information on this site is only allowed for necessary business reasons, and is restricted to those persons with a valid user name and password.

# Table of Contents

## List of Figures and Tables

# 1. Introduction

This document provides billing instructions for professional services provided to MaineCare members when submitting paper claims for processing in the Maine Integrated Health Management Solution (MIHMS). As alternatives to paper, providers are encouraged to submit claims using the HIPAA compliant EDI 837P format or by Direct Data Entry (DDE), which is an online process where data is directly entered into MIHMS for processing and payment. These paperless alternatives provide countless efficiencies for claims processing without the traditional problems associated with the submission of paper claims such as getting lost in the mail, data entry errors, delayed adjudication, etc. Providers electing to use DDE or EDI must register as a Trading Partner after successful enrollment in MaineCare.

The CMS 1500 form, previously known as the HCFA 1500 form, is a billing form maintained by the National Uniform Claims Committee (NUCC). Each payer, including MaineCare, has different requirements for completing specific parts of the claim form.

**Providers are encouraged to use these paper alternatives and may reach out for support by calling customer support at 1-866-690-5585.**

- Direct Data Entry is an option for MaineCare providers that will work well for providers who would like to submit Claims, Authorizations, and Referrals directly into MIHMS. These functions can be done one at a time or set up using rosters to make the entry easier.
- Providers may also submit batch transaction files in the HIPAA compliant X12 EDI format.
- Additional information can be found for these billing options at the MIHMS website at: https://mainecare.maine.gov/.

The instructions contained in this document are to be followed for completing the claim form for the submitted dates of service to include September 1, 2010 forward. Service dates prior to September 1, 2010 will not be processed by MIHMS, but will follow different billing instructions as specified in the MECMS billing requirements. Providers who need assistance with billing MECMS claims contact your State Provider Relations Specialist at 1-800-321-5557.

Each provider is responsible for obtaining their own CMS 1500 forms; the Maine Department of Health and Human Services (DHHS) does not provide them.

CMS 1500 forms are red printing on white paper. You can buy the forms at office supply centers or from other sources including:

U.S. Government Printing Office
Mail Stop: IDCC
732 N. Capitol St. NW
Washington, DC 20401
http://www.gpo.gov/

**General Guidance on Submitting Claims**

Claim types by MIHMS Provider Types are listed in the following table:

**Table 1: MIHMS Provider Types**

| MIHMS Provider Type | Policy Section | Rendering Provider Required | Claim Type | |
|---|---|---|---|---|
| | | | CMS1500 | UB04 |
| Adult Day Health | 19, 26 | **No** | √ | |

| MIHMS Provider Type | Policy Section | Rendering Provider Required | Claim Type | |
|---|---|---|---|---|
| | | | CMS1500 | UB04 |
| Advanced Practice Registered Nurse Group | 14, 96 | **Yes** | √ | |
| Advanced Practice Registered Nurse | 13, 14, 96 | **No** | √ | |
| Alternative Residential Facility | 2 | **No** | | √ |
| Ambulance<br>Note: Hospital owned Ambulance services should be billed on the UB form. | 5, 113 | **No** | √ | |
| Ambulatory Surgical Center<br>Note: Only Qualified Medicare Beneficiary (QMB) claims will be paid for this provider type. | N/A | **No** | √ | |
| Assisted Living Service Provider | 96 | **No** | √ | |
| Audiology (Group) | 35, 109 | **Yes** | √ | |
| Audiologist | 35, 109 | **No** | √ | |
| Behavioral Health Clinicians Group | 65 | **Yes** | √ | |
| Behavioral Health Clinician | 13, 65 | **No** | √ | |
| Boarding Home | 97 | **No** | | √ |
| Case Management | 12,13, 19, 22 & 96 | **No** | √ | |
| Children's Community Rehabilitation | 28 | **No** | √ | |
| Chiropractic Group | 15 | **Yes** | √ | |
| Chiropractor | 15 | **No** | √ | |
| Community Provider/ FQHC, RHC, IHS | 31, 103, 9 | **No** | | √ |
| Dialysis Center - Free Standing | 7 | **No** | | √ |
| DME Supplier | 35, 60 | **No** | √ | |
| Early Childhood | 28 | **No** | √ | |
| Family Planning Agency | 30 | **Yes** | √ | |
| Fiscal Employer Agent | 12, 19, 22 & 96 | **No** | √ | |
| Group Home - IID | 50 | **No** | | √ |
| Government Agency | 13 | | | |
| Home Health Agency | 19, 40 & 96 | **No** | | √ |

| MIHMS Provider Type | Policy Section | Rendering Provider Required | Claim Type | |
|---|---|---|---|---|
| | | | CMS1500 | UB04 |
| Hospice | 43 | **No** | | √ |
| Hospital (see notes below) / Hospital, Critical Access | 45 | **No** | | √ |
| Note: Hospitals are required to split bill their professional services to a CMS1500 in a manner that mirrors their Medicare billing. | various | **Yes** | √ | |
| Indian Health Services Provider<br>Note: IHS providers enrolling as a Community Provider must follow guidelines for that Provider Type. | 9 | **Yes** | √ | |
| Intermediate Education Unit | 28, | **No** | √ | |
| | 68, 85 &109 | **Yes** | √ | |
| Interpreter Services for Dental Providers<br>Note: Providers billing for interpreter services need to put the healthcare provider's rendering id on the claims. | 25 | **Yes** | √ | |
| Laboratory/Radiology | 55, 62 & 101 | **No** | √ | |
| Mental Health Clinic / Behavioral Health Services, Community Support Services | 17, 23, 65 | **Yes** | √ | |
| Developmental and Behavioral Health Clinic | | **No** | √ | |
| Mental Health Clinic - ACT | | **No** | √ | |
| Mental Health Clinic – Intensive Case Management | | **No** | √ | |
| Nurse | 13, 19, 96 | **No** | √ | |
| Nursing Home | 19, 26, 50, 67 & 97 | **No** | | √ |
| Occupational/Physical Therapy Group | 19, 68 & 85 | **Yes** | √ | |
| Occupational Therapist | 19 & 68 | **No** | √ | |
| Physical Therapist | 19 & 85 | **No** | √ | |
| Optician | 35, 75 | **No** | √ | |
| Optometrist | 75 | **No** | √ | |
| Pharmacy | 35, 80 | **No** | **None** | |

| MIHMS Provider Type | Policy Section | Rendering Provider Required | Claim Type | |
|---|---|---|---|---|
| | | | CMS1500 | UB04 |
| Physicians Group | 90 | Yes | √ | |
| Physician | 90 | No | √ | |
| PNMI - Private Non-Medical Institution | 97 | No | | √ |
| Podiatry Group | 95 | Yes | √ | |
| Podiatrist | 95 | No | √ | |
| PCA Agency | 19, 96 | No | √ | |
| Psychiatric Hospital | 46 | No | | √ |
| Note: Psychiatric Hospitals are required to bill their professional services in a manner that mirrors their Medicare billing | various | Yes | √ | |
| Public School | 28, 65 & 96 | No | √ | |
| | 68, 85 &109 | Yes | √ | |
| Rehabilitation Center | 102 | No | √ | |
| School Health Center | 3 | Yes | √ | |
| Special Purpose Private School | 28, 65, 68, 85, 96 &109 | No | √ | |
| Speech Language Pathology Group | 19, 109 | Yes | √ | |
| Speech Language Pathologist | 19, 109 | No | √ | |
| Speech/Hearing Therapist Group | 35, 109 | Yes | √ | |
| State Agency | 13, 17, 21, 65 | No | √ | |
| State Agency / Dentist Public Health | 25 | Yes | √ | |
| State Psychiatric Hospital | 46 | No | | √ |
| Substance Abuse Provider | 13, 65 | Yes | √ | |
| Transportation | 113 | No | √ | |
| Vision Center | 75 | No | √ | |
| Vision Services Provider Group | 35, 75 | Yes | √ | |
| Waiver Services Provider | 19, 20, 21, 22, 29,& 32 | No | √ | |
| Dental Group | 25 | Yes | ADA 2012 | |

| MIHMS Provider Type | Policy Section | Rendering Provider Required | Claim Type | |
|---|---|---|---|---|
| | | | **CMS1500** | **UB04** |
| Dental Hygienist Group | | **Yes** | **ADA 2012** | |
| Denturist Group | 25 | **Yes** | **ADA 2012** | |
| Dental Hygienist, Dentist, Denturist, | | **No** | **ADA 2012** | |
| Note: Oral Surgeons who provide services outside of Section 25 may bill MaineCare for those services using the CMS1500 | | | √ | |

1. Billing instructions are intended to assist providers with the preparation of claims, and are intended to supplement the guidance provided in the applicable MaineCare Policy. Policies may be accessed at the following website: http://www.maine.gov/sos/cec/rules/10/ch101.htm

2. Paper claims will be returned to the provider for any of the following reasons:
   - Not on an original Claim Form.
   - The form/attachment is incorrect, not legible, print is too light, and/or the alignment is not correct (1 character out of alignment or more).
   - Claim is damaged.
   - The form includes the use of any correction tape or liquid correction fluid or crossed out data.
   - Claim is completed with red ink.
   - Attachment is completed with red ink.
   - An attachment:
     - Is not 8 ½ x 11
     - Has double sided content
   - Federal Tax ID is less than 9 digits.
   - Patient's First and/or Last name are missing.
   - Patient's Date of Birth is missing or not in MMDDCCYY format.
   - Claim does not have at least one line of detail in lines 24 with data in A and D.
   - Signature (typed or stamped is acceptable) and/or date is missing.
   - NPI is less than 10 digits or API is less than 10 characters (A followed by 9 digits).
   - If Insured's ID # is not in one of these four valid formats:
     - Eight digits followed by A
     - Eight digits followed by T
     - Six digits preceded by T, or
     - Six digits followed by T

*Note: Additionally, paper claims are translated to an EDI X12 transaction and will be returned for any HIPAA validation errors. Providers will receive a letter indicating the claim is being returned for HIPAA.*

3. Codes

- Use Current Procedural Terminology (CPT) of the American Medical Association, ICD (International Classification of Diseases) Diagnostic Codes, or Healthcare Common Procedure Coding System (HCPCS) Codes maintained by the Centers for Medicare and Medicaid Services, or,

- Use the Procedure Codes in the applicable Chapter III of the MaineCare Benefits Manual policy section. Access to these codes can be found at the following website: http://www.maine.gov/sos/cec/rules/10/ch101.htm

- The following codes are not listed in each section of policy, but must be used when billing interpreter services:

  o T1013 Sign language or oral interpreter services per fifteen minutes.

  o T1013-GT Interpreter Services provided via documented use of Pacific Interpreters, Language Line, or equivalent telephone interpreting service must be by report with copies of the invoice attached.

4. Special Instructions

- Some providers who use the CMS 1500 form need to follow special instructions for certain fields. Special instructions are listed for each field.

5. Dates

- The required format for most dates is eight digits (MMDDCCYY).
  o Example: January 19, 1947= 01191947

- The date format for service may be either six (6) digits (MMDDYY) or eight (8) digits (MMDDCCYY).
  o Example: January 19, 1947= 011947

6. Multi-paged claim

- Page Total: Do not put the total claim amount on any first or intermediate page.
  o The total must be placed on the last or final page of the multiple-paged claim. If the total is placed on each page, MaineCare will consider the page a stand-alone claim.

- Fill out header information on each page with identical information. This will help ensure that the claim pages are kept together.

- Other than Service Lines and Totals, only header information from page 1 will be used for actually processing the claim.
  o Attachments (e.g., operative notes) for a multiple-page claim will be placed after the last page of the claim, and the attachment(s) will be secured with a paperclip.

- Put page numbering for multi-page claims (in the format *page* of *total pages*) in the open area in the upper right hand area of the claim form.

7. Mailing Claims

- Send the Claim Form, including replacement or reversal claims, to:

  MaineCare Claims Processing
  M-500
  Augusta, ME 04332-0011

8.  Attachments and Attachment Uploads

- Attachments may be provided in any of the following ways:
    o Attach paper attachment to a paper claim.
    o Attachments may be uploaded through the Portal when submitting claims via Direct Data Entry.
    o Attachments may be uploaded through the Portal for previously submitted claims by searching for the matching claim in Claims Status and uploading a scanned attachment directly to the claim.
        ▪ Acceptable file formats for upload are: PDF, GIF, JPEG/JPG, TIFF, MS Word, and MS Excel.
        ▪ **Attachments must be submitted on the same day.  If appropriate attachment is not present when the claim is being reviewed, it will deny.**
        ▪ For detailed instructions regarding uploading attachments through the Portal, refer to the appropriate MHP User Guide at the following link: https://mainecare.maine.gov/MyHealth%20PAS%20User%20Guides/Forms/Publication%20View.aspx

- When submitting claims after Medicare C Plans, write "Medicare" on the Explanation of Benefits.

- Spend down letters should be attached for each claim where the member has a coverage code of "Spend Down" for that particular date of service.

- Abortion form should be submitted along with the claim.  This service is not prior authorized.  Submit the required documentation along with the claim form after the service is performed.  The form is signed by the physician and attests to certain conditions.

9. Billing for Non-Covered Medicare Services

- Occasionally, there are services for which MaineCare pays, when Medicare does not cover them.  For claims to process appropriately, the claim that is submitted to MaineCare must be billed in the same manner as it is when billing MaineCare as the primary payer.
    o Non-hospital providers:
        ▪ UB04: FL50, line "A" must reflect the word "MaineCare", FL58 and FL60 must reflect the member's name and MaineCare ID respectively.
        ▪ UB04 and CMS1500: Attach the Explanation of Medicare Benefits (EOMB), and at the top of the EOMB write "non-covered charges".  **Do not write on the claim, only on the EOMB.**

- If submitting a claim that includes both covered and non-covered services previously billed to Medicare, the covered and non-covered services must be billed to MaineCare on separate claims.  Appendix A: includes a summary for Third Party Billing.

10. Field Usage

- These instructions include description of whether each Box is Required, Situational, Optional, or Not Used, according to these definitions:

    o   Required– This item must be completed with the proper information as specified.

    o   Situational– This item must be completed with the proper information, if the stated triggering event applies.

    o   Optional– This item can be completed at your discretion (for example, to avoid having to file claims differently for MaineCare), but if used, must contain the information as specified by the AMA guidelines, or as superseded by these instructions, if they differ.

    o   Not Used– This item need not be completed as MaineCare/MIHMS never looks at this field.

# 2. CMS 1500 Claim Form



**Figure 2-1: CMS 1500 Form**

# 3. Form Instructions

The form instructions will describe how each field should be filled out using either Required, Situational, or Not Required.

## *3.1    BOXES 1 through 1a*



**Figure 3-1: Boxes 1 through 1a**

### Box 1: Carrier Information

- Not Labeled on the CMS1500
- Required
  - o Enter an X in the Medicaid box for a MaineCare claim.

### Box 1a: Insured's I.D. Number

- Required
  - o Enter the members' MaineCare Identification number.
  - o To verify a member's MaineCare eligibility:
    - ▪ Use MyHealth PAS online portal; or
    - ▪ Submit a 270 EDI Request for Eligibility verification request, or
    - ▪ Use the Interactive Voice Response system (IVR)

## *3.2    BOXES 2 through 8:*



**Figure 3-2: Boxes 2 through 8**

### Box 2: Patient's Name

- Required
  - o Enter the member's name exactly as it appears on his/her MaineCare eligibility card: last name, first name, and middle initial.

### Box 3: Patient's Birth Date and Sex

- Required
  - o Enter member's date of birth.
  - o Must be in MMDDCCYY format, e.g., 10122009.
  - o Enter an X in the appropriate M or F checkbox.

## Box 4: Insured's Name

- Not Used

## Box 5: Patient's Address

- Required
  - Enter the address of the MaineCare member

## Box 6: Patient's Relationship to Insured

- Not Used

## Box 7: Insured's Address

- Not Used

## Box 8: Reserved for NUCC Use

- Not Used

## 3.3   BOXES 9 through 9d



**Figure 3-3: Boxes 9 through 9d**

## Box 9: Other Insured's Name

- Situational (If the MaineCare member is covered by other primary insurance, and required if "Yes" is checked in Box 11d.)
  - If the member is covered by a primary insurance, submit the claim to other insurers prior to submitting the claim to MaineCare.
    - Attach a copy of the Explanation of Benefits or Remittance Statement from the primary insurance.
  - Enter the name of the policyholder.
    - Do not enter Medicare Part A/B or any other State program information.
  - If this box is completed, also complete Boxes 9a and 9d.
  - If there is no other insurance, leave this box and all fields (9–9d) blank.

## Box 9a: Other Insured's Policy or Group Number

- Situational (Required if "Yes" is checked in Box 11d).
  - Enter the policy or group number of the primary insurance.

## Box 9b: Reserved for NUCC Use

- Not used

## Box 9c: Reserved for NUCC Use

- Not Used.

## Box 9d: Insurance Plan Name or Program Name

- Situational (Required if a person is listed in Box 9, and required if "Yes" is checked in Box 11d)
  - o Enter the name of the primary insurance plan or program name. (Example: Anthem Blue Cross Plan B).
  - o When billing for Medicare C (Medicare Advantage Plans), the payer name must be spelled out as "Medicare".

## 3.4 BOXES 10 through 10d



**Figure 3-4: Boxes 10 through 10d**

## Box 10: Is Patient's Condition Related To:

- Situational
  - o Check appropriate box if the treatment is related to employment, an auto accident or other accident.

## Box 10a: Employment? (Current or Previous)

- Situational
  - o Check appropriate box if the treatment is related to current or previous employment.

## Box 10b: Auto Accident? (Enter State)

- Situational
  - o Check appropriate box if the treatment is related to an auto accident.
  - o Indicate the two letter State abbreviation for the State where the accident occurred.

## Box 10c: Other Accident?

- Situational
  - o Check appropriate box if the treatment is related to other accident.

## Box 10d: Claim Codes (Designated by NUCC)

- Situational
  - Use the appropriate claim code to identify additional information about the patient's condition or the claim. Applicable claim codes are designated by the NUCC.
  - When reporting more than one code, enter three blank spaces and then the next code.
  - **FOR WORKERS COMPENSATION CLAIMS:** Condition Codes are required when submitting a bill that is a duplicate or an appeal. (Original Reference Number must be entered in Box 22 for these conditions). **Note:** Do not use Condition Codes when submitting a revised or corrected bill.

**Table 2: Condition Codes for CMS 1500**

| Code | Description |
|------|-------------|
| AA | Abortion performed due to Rape |
| AB | Abortion performed due to Incest |
| AC | Abortion Performed due to Serious fetal genetic defect, deformity, or abnormality |
| AD | Abortion performed due to a life endangering physical condition caused by, arising from or exacerbated by the pregnancy itself |
| AE | Abortion performed due to physical health of mother that is not life endangering |
| AF | Abortion performed due to emotional/psychological health of the mother |
| AG | Abortion performed due to social or economic reasons |
| AH | Elective abortion |
| AI | Sterilization |
| Worker's Compensation Claim Codes | |
| W2 | Duplicate of original bill |
| W3 | Level I appeal |
| W4 | Level 2 appeal |
| W5 | Level 3 appeal |

## *3.5   BOXES 11 through 11d*



**Figure 3-5: Boxes 11 through 11d**

### Box 11: Insured's Policy Group or FECA Number

- Situational
  - Complete if "Y" is checked in Box 11d.

### Box 11a: Insured's Date of Birth and Sex

- Not Used

### Box 11b: Other Claim ID

- Not Used

### Box 11c: Insurance Plan Name or Program Name

- Not Used

### Box 11d: Is There Another Health Benefit Plan?

- Required
  - If the MaineCare member is covered by other primary insurance even if the member is not the policyholder, enter an X in the YES box and also complete Fields 9, 9a, and 9d.
  - Enter an X in the "No" box if the member has Medicare, Medicare C, or is covered by any other State program
  - If there is no other insurance, enter an X in the NO box

## *3.6   BOXES 12 through 13*

### Box 12: Patient's Or Authorized Person's Signature

- Not Used

### Box 13: Insured's or Authorized Person's Signature

- Not Used

## 3.7   BOXES 14 through 16

| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) | 15. OTHER DATE | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION |
|---|---|---|---|
| MM    DD    YY          QUAL. | QUAL. | MM    DD    YY | MM    DD    YY           MM    DD    YY
FROM                          TO |

**Figure 3-6: Boxes 14 through 16**

### Box 14: Date of Current Illness, Injury or Pregnancy (LMP)

- Situational (Required if 10 a, b, or c are checked as Yes and/or if pregnant).
  - Enter the applicable date.
  - Can be either MMDDYY or the MMDDCCYY format.
  - For pregnancy, use the date of the last menstrual period (LMP) as the first date
- Enter the applicable qualifier to identify which date is being reported. Enter the qualifier to the right of the vertical dotted line.
  - 431: Onset of Current Symptoms or illness
  - 484: Last Menstrual Period

### Box 15: Other Date and Qualifier

- Situational, (Required if 10 a, b, or c are checked as Yes and/or if pregnant)..
  - Enter another date related to the patient's condition or treatment. Can be either MMDDYY or MMDDCCYY format.
- Enter the applicable qualifier to identify which date is being reported. Enter the qualifier between the left-hand set of vertical dotted lines.

**Table 3: Qualifiers**

| Qualifier | Description |
|---|---|
| 454 | Initial Treatment |
| 304 | Latest Visit or Consultation |
| 453 | Acute Manifestation of a Chronic Condition |
| 439 | Accident |
| 455 | Last X-Ray |
| 471 | Prescription |
| 090 | Report Start (Assumed Care Date) |
| 091 | Report End (Relinquished Care Date) |
| 444 | First Visit or Consultation |

### Box 16: Dates Patient Unable to Work in Current Occupation

- Not Used

## 3.8   BOXES 17 through 20

| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES |
|---|---|---|---|
| | 17b. NPI | | MM    DD    YY           MM    DD    YY
FROM                          TO |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | 20. OUTSIDE LAB?          $ CHARGES
☐ YES   ☐ NO |

**Figure 3-7: Boxes 17 through 20**

## Box 17: Name of Referring Physician or Other Source

- Situational (Required if member is part of Primary Care Case Management (PCCM) Program).
  - Referral Name is required if the member is enrolled in MaineCare PCCM and the specialty service requires a referral from the Primary Care Provider (PCP) site.
- Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. Do not use periods or commas. A hyphen can be used for hyphenated names.
  - If multiple providers are involved, enter one provider using the following priority order:
    1. Referring Provider
    2. Ordering Provider
    3. Supervising Provider
- Enter the applicable qualifier to identify which provider is being reported. Enter the qualifier to the left of the vertical dotted line.

**Table 4: Provider Qualifiers**

| Qualifier | Description |
|-----------|-------------|
| DN | Referring Provider |
| DK | Ordering Provider |
| DQ | Supervising Provider |

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
DN Jane A Smith MD

**Figure 3-8: Provider Qualifier Example**

## Box 17a: Other ID#

- Situational
  - Required if Box 17B is left blank.
- The non-NPI ID number of the referring, ordering, or supervising provider is the unique identifier of the professional or provider designated taxonomy code.
- Enter the applicable qualifier to indicate the type of number reported in 17a. The qualifier is reported to the immediate right of 17a.

**Table 5: Other ID Qualifier**

| Qualifier | Description |
|-----------|-------------|
| 0B | State License Number |
| 1G | Provider UPIN Number |
| G2 | Provider Commerical Number |
| LU | Location Number (used with Supervising Provider only) |

## Box 17b: NPI

- Situational: Required if 17 is completed.
  - Enter PCP's 10 digit NPI number.

## Box 18: Hospitalization Dates Related to Current Services

- Not Used

## Box 19: Additional Claim Information (Designated by NUCC)

- Situational (Required if member is part of Primary Care Case Management (PCCM) Program).
- Enter the appropriate Referral ID #

## Box 20: Outside Lab?

- Not Used

## *3.9 BOXES 21 through 23*



**Figure 3-9: Boxes 21 through 23**

## Box 21: Diagnosis or Nature of Illness or Injury

- Required
    - Enter the Applicable ICD indicator to identify which version of ICD codes is being reported. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.
        - 9: ICD-9-CM
        - 0: ICD-10-CM
    - Enter the numeric International Classification of Diseases (ICD) code.
        - Use the code that is as specific as possible, according to ICD coding guidelines.
            - Do not enter the description of the diagnosis code.
        - Decimal points are required If there is more than one diagnosis, enter each diagnosis code separately.
        - Enter no more than 12 diagnoses.
            - Enter the diagnosis codes most relevant to the procedure being billed.
        - Relate lines A-L to the lines of service in 24E by the letter of the line.
        - Ambulance claims must include a diagnosis code. For dates of service prior to 10/01/2015, use 780.99 (Other General Symptoms). For dates of service of 10/01/2015 and forward, use the appropriate ICD-10 code: R45.84 (anhedonia) or R68.89 (other general symptoms and signs).

## Box 22: Resubmission Code/Original Ref. No.

- Situational (Required for Reversals and Replacements).
    - If this is a correction to a previously processed claim, in the Medicaid Resubmission Code Box, enter one of the following:
        - 7– for **Replacement** of a previous claim.
        - 8– for **Reversal** or Void.
    - In the Original Ref. No. Box, enter the previous Claim ID. Adjustments must be done at the claim level.

## Box 23: Prior Authorization Number

- Situational  (Required for services where multiple Prior Authorizations ("PAs") exist for the same date, service, member and provider ).
    - o  Enter the PA number issued by the authorizing unit for the services or supplies being billed  on this form.
    - o  Bill  only one PA number on each claim form.
    - o  All  services billed on the claim should be included in the PA.
    - o  A PA number submitted on the claim form must exactly match the authorization number in MIHMS including both alpha and numeric characters. (e.g. APS1234567890 or EIS0000000-011)

## *3.10  BOX 24: Service A - J*



**Figure 3-10: Box 24, Service A- J**

Repeat Boxes 24 A through J for any additional services/procedures rendered.  Multi paged claims are acceptable.

- At least one line is required.
    - o  For each line item billed,  include one date, one place of service, one procedure code, and one amount charged per line.
    - o  See Appendix A for a summary of Third Party Billing  Instructions.
    - o  The shaded area on each line is for supplemental information.
        - ▪  It is not intended to allow the billing of 12 service lines.

## Box 24A: Dates of Service

- Required
    - o  If the service was provided on only one day, enter that date in the From Box and leave the To Box blank.
    - o  From and To dates on each line must be consecutive and continuous.
        - ▪  On each line, the From and To dates must be during a single calendar month.
        - ▪  Use the next line for any dates of service occurring in the next calendar month.
    - o  Can be either MMDDYY or the  MMDDCCYY format.

*NOTE: For most claims, services prior to and on or after 10/01/2015 need to be billed on separate claims. For claims with dates of service of 10/01/2015 and forward, use the appropriate ICD-10-CM code. For claims with dates of service prior to 10/01/2015, use the appropriate ICD-9-CM code, with the following exceptions:*

- *Claims with services prior to and on or after 10/01/2015 can be billed on the same claim form if the claim is a DMEPOS claim. If the DMEPOS claim has a from date prior to 10/01/2015 and a*

*through date on or after 10/01/2015, the entire claim is billed using ICD-9-CM codes based on the from date of service.*

- *Claims with anesthesia procedures that begin on 09/30/2015, but end on 10/01/2015, are to be billed with ICD-9 diagnosis codes and use 09/30/2015 as both the FROM and THROUGH date.*

## Box 24B: Place of Service

- Required
  - o Enter the appropriate two-digit place of service code(s) from the list provided.
    - ▪ Identify the location, using a place of service code, for each item used or service performed.
    - ▪ **Durable Medical Equipment and Supplies Providers:** Use the Place of Service code where the member resides.

**Table 6: Place of Service Code List**

| Place of Service Code List: | | | |
|---|---|---|---|
| 01 | Pharmacy | 03 | School |
| 04 | Homeless Shelter | 05 | Indian Health Service Free-standing Facility |
| 06 | Indian Health Service Provider-based Facility | 07 | Tribal 638 Free-standing Facility |
| 08 | Tribal 638 Provider Based Facility | 11 | Office |
| 12 | Home | 13 | Assisted Living Facility |
| 14 | Group Home | 15 | Mobile Unit |
| 17 | Walk-in Retail Health Clinic | | |
| 20 | Urgent Care Facility | 21 | Inpatient Hospital |
| 22 | Outpatient Hospital | | Should be used when a provider qualifies as a "Provider Based" entity under 42CFR413.65. |
| 23 | Emergency Room – Hospital | 24 | Ambulatory Surgical Center |
| 25 | Birthing Center | 31 | Skilled Nursing Facility |
| 32 | Nursing Facility | 33 | Custodial Care Facility |
| 34 | Hospice | 41 | Ambulance – Land |
| 42 | Ambulance – Air or Water | 49 | Independent Clinic |
| 50 | Federally Qualified Health Center | 51 | Inpatient Psychiatric Facility |
| 52 | Psychiatric Facility – Partial Hospitalization | 53 | Community Mental Health Center |
| 54 | Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) | 55 | Residential Substance Abuse Treatment Facility |
| 56 | Psychiatric Residential Treatment Facility | 57 | Non-Resident Substance Abuse Treatment Facility |
| 61 | Comprehensive Inpatient Rehabilitation Center | 62 | Comprehensive Outpatient Rehabilitation Center |
| 65 | End Stage Renal Disease Treatment Facility | 71 | State or Local Public Health Clinic |

| Place of Service Code List: | | | |
|---|---|---|---|
| 72 | Rural Health Center | 81 | Independent Laboratory |
| | | 99 | Other |

## Box 24C: EMG

- Situational
    - For services delivered during an emergency situation that typically require Prior Authorization, a "Y" must be entered in this box. Providers must maintain supporting documentation on file.
    - An appropriately entered "Y" submitted in this box will prevent a copay from being deducted for services subject to a copay.
        - Refer to Chapter I of the MaineCare Benefits Manual for a list of services exempt from copays. http://www.maine.gov/sos/cec/rules/10/ch101.htm

## Box 24D: Procedures, Service or Supplies



**Figure 3-11: Box 24D, Procedures, Service or Supplies**

- Required
    - Enter the appropriate procedure code and modifier(s) in the unshaded area, if appropriate. Procedure codes and modifiers may be found in:
        - Chapter III of the MaineCare Benefits Manual and on the MaineCare Services website, or http://www.maine.gov/sos/cec/rules/10/ch101.htm

        - The CMS Healthcare Common Procedure Coding System (HCPCS) code adding the HCPCS code modifiers when appropriate.
    - When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line.
        - The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). The 11-digit NDC number is printed on the drug package in a 5-4-2 format. If the segments do not have the appropriate number of digits, you will need to add zeros at the beginning of the segment.

- Report the NDC quantity in the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram), ML (milliliter) or ME (milligrams). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).
- All ingredients that make up a compound prescription must be identified on the claim and a unique HCPCS must be assigned to each ingredient. Each HCPCS must be entered as a separate line item. The associated units, NDC number, the NDC Drug Quantity, and the Composite unit of measure must also be reported.
- When entering NDC, only column D is used; all other columns are blank on that line.
  - Modifiers
    - The Form CMS-1500 has the ability to capture up to four modifiers.
    - Use appropriate modifiers when billing for serious reportable events.
  - CRNAs
    - CRNAs bill with the QZ modifier for a CRNA service, without medical direction by a physician and a QX for CRNA service with the medical direction by a physician.
  - Repair/Replacement Procedures must be billed with the RA or RB modifiers as appropriate.
  - Bi-lateral procedures require the code with the 50 modifier on one claim line.
    - Procedure is reimbursed at 150% of the allowed amount.
  - Family Planning services must be billed using FP modifier.
    - Family planning services are those provided to prevent or delay pregnancy or to otherwise control family size. Counseling services, laboratory tests, medical procedures and pharmaceutical supplies and devices are covered if provided for family planning purposes.
  - State Supplied Vaccines require the use of the SL modifier on both the administration code and the vaccine code.
  - Ambulance Providers:
    - Ambulance providers should insert the H9 modifier before the origin/destination code, when appropriate.
    - In the Modifier Box, enter the appropriate two letters for the transport's place of origin and destination from the following list:

**Table 7: Transportation Origin/Destination Codes**

| Code | Description |
|------|-------------|
| D | Diagnostic or therapeutic site other than P or H |
| E | Residential domiciliary, custodial facility (nursing home, not skilled nursing facility) |
| G | Hospital-based dialysis facility (hospital or hospital-related) |
| H | Hospital |
| I | Site transfer (ie: airport or helicopter pad) between modes of ambulance transport |
| J | Non-hospital-based dialysis facility |

| Code | Description |
|------|-------------|
| N | Skilled Nursing Facility (SNF) |
| P | Physician's office (includes HMO non-hospital facility, clinic, etc.) |
| R | Residence |
| S | Scene of accident or acute event |
| X | (Destination code only) intermediate stop at physician's office enroute to the hospital (includes HMP non-hospital facility, clinic, etc.) |
| QL | Patient pronounced dead after ambulance called |
| UC | Unclassified ambulance service |

- o Ambiguous Gender Category:
  - ▪ KX modifier should be used to identify services that are gender specific (i.e., services that are considered female or male only.) This modifier should only be used on claims relating to transgender, ambiguous genitalia or hermaphrodite issues.

## Box 24E: Diagnosis Pointer



**Figure 3-12: Box 24E Diagnosis Pointer**

- Required
  - o From Box 21, enter the line letter or letters (A-L) that identify the relevant diagnosis code(s) for the service line.
    - ▪ List only the line letter(s).
    - ▪ Do not enter the codes themselves.
    - ▪ List up to 4 characters in the unshaded area.
    - ▪ Enter letters left justified. Do not use commas between the letters.
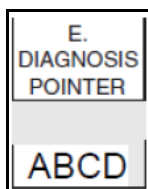
**Figure 3-13: Diagnosis Pointer Example**

## Box 24F: Charges

- Required
  - Enter the usual charge for the service provided.
    - For more information on charges, see the MaineCare Benefits Manual http://www.maine.gov/dhhs/oms/provider/provider_index.html
  - Must be in valid currency format: dd.cc, e.g., 24.00.
  - Do not put a $ sign before the total. The $ can be picked up as an 8.

## Box 24G: Days Or Units

- Required
  - Enter the number of days of service or the units of supplies provided.
  - Do not use decimal points or fractions.
  - Units must be whole numbers.
    - do not use ¼, ½, ¾, etc.
    - In cases where services provided include less than a whole unit of a service, the unit shall be rounded up only if equal to or greater than fifty percent (50%) of the unit of service, e.g. 1.5 units of service equals 2 units of service rounded up; 1.4 units of service equal 1 unit of service. The procedure code for the smallest unit of service must be used.
    - Specific provisions in any other Chapters or Sections of this Manual will supersede this rounding requirement.
  - Actual anesthesia time in minutes is reported in 24G.
  - To find the definition of a unit, refer to the code descriptions or maximum allowance column in Chapter III of the MaineCare Benefits Manual, or refer to the CPT and HCPCS standard code listings.

## Box 24H: EPSDT Family Plan

- Required
  - Enter a "Y" if the service is EPSDT. Enter a "N" if the service is not EPSDT.
- Early Periodic Screening Diagnosis and Treatment is known as "Bright Futures" in Maine.

## Box 24I: ID. Qual.

- Not Used
  - Form is precompleted with the word "NPI" in the non-shaded area of the line.

## Box 24J: Rendering Provider ID #

- Situational (Required if Provider Type is listed below):
  - Enter the applicable NPI.

o Providers billing for interpreter services need to put the healthcare provider's rendering id on the claims.

o A claim form may have only one (1) rendering NPI. The same rendering provider could bill multiple services on a single claim.

**Table 8: Provider Types Requiring Renderings**

| Provider Types Requiring Renderings |
|---|
| Advanced Practice Registered Nurse Group |
| Audiology Group |
| Behavioral Health Clinicians Group |
| Chiropractic Group |
| Dental |
| Family Planning Agency |
| Hospital Based Professionals |
| Indian Health Services Provider |
| Intermediate Educational Unit (for therapy services) |
| Mental Health Clinic/Behavioral Health Services, Community Support Services |
| Non-Hospital Affiliated Clinic |
| Occupational/Physical Therapy Group |
| Physicians Group |
| Psychiatric Hospital Professional Services |
| Podiatry Group |
| Public School (for therapy services) |
| School Health Center |
| Speech Language Pathology Group |
| Speech/Hearing Therapist Group |
| State Agency/Dentist Public Health |
| Substance Abuse Provider |
| Vision Services Provider Group |

## *3.11 BOXES 25 through 33*



**Figure 3-14: Boxes 25 through 33**

### Box 25: Federal Tax I.D. Number

- Required

- o Enter the TAX ID number matching the Pay To NPI/API.
- o Enter an X to identify the number as a Social Security Number (SSN) or an Employer Identification Number (EIN).

## Box 26: Patient's Account No.

- Required
  - o Enter the provider internal patient number/identifier in this location. (Maximum length 38 but MaineCare will only return 20 characters on the remittance advice (RA) or 835).
  - o Field may be alpha numeric
    - ▪ Examples:
      - ▪ 123456
      - ▪ Smith, John
      - ▪ Smit1234

## Box 27: Accept Assignment

- Not Used

## Box 28: Total Charge

- Required
  - o Total the charges in Box 24, Column F, and enter the amount.
    - ▪ For multi-page claims, enter the total for all pages on the last page.
      - • Claims with totals on each page will be considered as individual claims.
  - o Must be in valid currency format, dd.cc, e.g., 24.00. Do not put a $ sign before the total. The $ can be picked up as an 8.

## Box 29: Amount Paid

- Situational (Required when billing after insurance).
  - o If billing after other insurance, attach an EOB.
  - o Enter the insurance payment in this Box and/or enter spenddown amount here. Attach spenddown letter.
  - o Must be in valid currency format, dd.cc, e.g., 24.00. Do not put a $ sign before the total. The $ can be picked up as an 8.

## Box 30: Reserved for NUCC Use

- Not Used

## Box 31: Signature of Physician or Supplier

- Required
  - o Enter the signature of the provider of service or supplier, or his/her representative, and either the 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date the form was signed.
    - ▪ The signature may be typed or stamped.
    - ▪ Do not use "signature on file".
    - ▪ Degree or credentials are not required.

## Box 32: Service Facility Location Information

- Required
  - o Enter the physical address of the facility where services are rendered (ex. Hospital or Nursing Home for a private practice physician).

## Box 32a: Not Labeled

- Not Used

## Box 32b: Service Location ID

- Not labeled on the CMS1500.
- Situational (Required when a provider has more than one (1) location)
    - The service location ID is needed IF the provider has enrolled with more than one service location within MaineCare.
    - Service Location ID: 10 Digit NPI or API plus the 3 digit servicing location identifier of -001, -002, etc.(ex. 1234567890-003).

## Box 33: Billing Provider Info & PH. # ID

- Required
    - Enter the billing provider's Pay-To address and phone number that matches W-9 information on file with the State Controller's office.
        - All Pay To address changes must be made through AdvantageME.

## Box 33a: NPI-Pay To

- Not labeled on the CMS1500.
- Situational (An entry must be included in either 33a or 33b).
    - Enter the 10-digit billing provider's National Provider Identifier (NPI).
        - Sometimes referred to as the "Pay-To" NPI.

## Box 33b: API

- Not labeled on the CMS1500.
- Situational (An entry must be included in either 33a or 33b).
    - Enter the Providers Atypical Provider Number or API.

# Appendix A

Appendix A contains summarized billing instructions for billing MaineCare as the secondary or tertiary payer after any other insurance coverage.

These instructions apply for any of the following:

- For paper claims.
- MaineCare does process claims after Medicare as part of the Coordination of Benefits Agreement (COBA) file transmitted from Medicare.
- Providers must bill any third party payer prior to billing MaineCare.
- Billing for services after Medicare and Medicare C plans.
- Billing secondary and tertiary claim after traditional insurance plans and fee for service managed care plans.

Complete the CMS 1500 claim form according to MaineCare requirements, along with the following:

- Box 24F: An amount not to exceed the provider's usual and customary charges to the general public
- Box 28: Enter the total charges.
    - This must equal the total of the individual line item charges in 24F.
- Box 29: Enter the amount paid by the insurance company/third party.
    - This amount must be entered on the claim form.

Additional Instruction:

- The third party EOB must be attached to the claim form.
- A provider cannot charge the member the copay.